U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 14 November 2002

CASE NO. 2000-BLA-174

In the Matter of

RAY DUCKWORTH
Claimant

v.

EASTERN ASSOCIATED COAL CORPORATION
Employer

and

DIRECTOR, OFFICE OF WORKERS
COMPENSATION PROGRAMS
Party-in-Interest

C. Patrick Carrick, Esquire
For the Claimant

W. William Prochot, Esquire
Paul E. Frampton, Esquire
For the Employer

Andrea J. Appel, Esquire
For the Director, OWCP

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.

Procedural History

The tortuous procedural history of this case began on June 29, 1973, when the Claimant, Ray Duckworth, filed his initial claim for Federal black lung benefits with the Social Security Administration (DX 1). The foregoing claim was repeatedly denied by the Social Security Administration (DX 33) and the Department of Labor (DX 34). The most recent denial was issued by the Department of Labor on July 25, 1980, when the Office of the Deputy Commissioner (now known as the District Director) found that the evidence did not show: that the Claimant has pneumoconiosis, or, that the disease was caused at least in part by coal mine work, or that the Claimant was totally disabled by the disease (DX 34). Since the Claimant did not appeal nor take any further action within one year of the July 25, 1980 denial, the initial application is deemed finally denied and administratively closed.

The current (duplicate or additional) claim was filed on March 13, 1984 (DX 1). It was denied by the Deputy Commissioner on June 1, 1984 (DX 35). Following Claimant's timely request (DX 40), a formal hearing was held before the undersigned on September 26, 1986 (DX 44-B). Subsequently, I issued an Order of Remand, dated May 20, 1987, in which I found that Claimant had established pneumoconiosis arising out of coal mine employment, but remanded the case to the Deputy Commissioner for clarification of Dr. Lapp's post-hearing medical report, and possible examination by another cardiologist, in order to determine whether the Claimant suffered from cor pulmonale, and thereby address the total disability issue (DX 44-A).

Following the further development of evidence, I issued a Decision and Order on Remand - Awarding Benefits, dated December 20, 1990 (DX 81). The focus of the foregoing decision was on the total disability issue; in particular, whether the Claimant suffered from cor pulmonale with right-sided congestive heart failure; and, if so, whether such condition was an occupationally-related pulmonary disease. In summary, I stated the following:

> In conclusion, notwithstanding the nonqualifying pulmonary function and arterial blood gas tests, and Dr. Lapp's opinion that Claimant's disabling cardiac disease is not occupationally related, I find that the preponderance of the medical evidence establishes that Claimant is totally disabled due to pneumoconiosis, as provided in § 718.204(b) and (c).
>
> Finally, assuming arguendo that the record was re-opened in its entirety, and my conclusions regarding the presence of pneumoconiosis and its relationship to coal mine employment were not deemed final, I would nevertheless award benefits to the Claimant based upon my consideration of the entire record, including the additional medical evidence (DX 59-69), which had not been authorized by my Order of Remand.

(DX 81, p. 5).

On appeal, the Benefits Review Board initially issued a Decision and Order, dated June 16, 1992, affirming my decision awarding benefits (DX 91). However, the Employer subsequently filed a timely Motion for Reconsideration (DX 94). Thereafter, the Benefits Review Board issued a Decision and Order on Reconsideration, dated January 31, 1995, granting Employer's Motion for Reconsideration and vacating my finding of pneumoconiosis under § 718.202(a)(1) (DX 95). In making this determination, the Board noted that, subsequent to my Decision and Order on Remand, the U.S. Supreme Court issued its decision in *Director, OWCP v. Greenwich Collieries [Ondecko]*, 114 S. Ct. 2251, 18 BLR 2A-1 (1994), *aff'g sub nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 BLR 2-64 (3d Cir. 1993), holding that the true doubt rule is not valid (DX 95).[1]

Following my receipt of the case file from the Benefits Review Board, I issued an Order of Remand, dated November 30, 1995 (DX 100). In pertinent part, I found that the most recent medical evidence in the record is stale, the latest being approximately seven years old. Accordingly, I remanded the case to the District Director's office so that the District Director could obtain an independent medical evaluation. Furthermore, I expressly stated: "I am not inviting additional testing by the parties." (DX 100). However, pursuant to Employer's motion, I subsequently issued an Order, dated February 13, 1996, allowing the parties to further develop medical evidence and respond to evidence developed by the District Director's office (DX 102, 111).

Following the further development of the evidence and a formal hearing before Administrative Law Judge Gerald M. Tierney on October 11, 1996 (DX 127), Judge Tierney issued a Decision and Order on Remand, dated August 14, 1997, awarding benefits (DX 130). However, on appeal, the Benefits Review Board issued a Decision and Order, dated September 30, 1998, in which Judge Tierney's Decision and Order on Remand was affirmed in part, vacated in part, and remanded for further consideration consistent with its opinion (DX 149). In pertinent part, the Board stated: 1) On remand, the administrative law judge must make a proper finding regarding the material change in conditions issue. 2) The administrative law judge failed to consider three negative x-ray rereadings, which had been timely submitted under cover letter, dated September 26, 1996. 3) The administrative law judge must explain the weighing and crediting of the x-ray evidence. 4) The administrative law judge must more thoroughly discuss and weigh the relevant evidence regarding the existence of pneumoconiosis, such as, the relative weight accorded to the opinion of Drs. Rasmussen, Renn, and Fino. 5) The administrative law judge must reconsider the total disability issue under § 718.204; and, in particular, assess the exertional requirements of Claimant's last usual coal mine employment, when weighing Dr. Rasmussen's opinion. 6) The administrative law judge must apply the Fourth Circuit's standard regarding the causation issue, which requires that the evidence demonstrate that coal

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[1]In the Decision and Order Awarding Benefits, I had relied upon the now discredited "true doubt" principle, "despite the numerical majority of negative B-readings." (DX 81, pp. 5-6).

mining is a necessary condition of the miner's disability. 7) Finally, if applicable, the administrative law judge should consider whether the evidence establishes a date when total disability due to pneumoconiosis began. (DX 149).

On April 27, 1999, Judge Tierney noted some procedural problems with the documentary evidence, and issued an Order remanding the case to the District Director's office for further evaluation (DX 157). On July 29, 1999, the District Director issued a Proposed Decision and Order denying benefits (DX 177). By letter, dated August 18, 1999, the Claimant filed a timely request for a formal hearing (DX 175). Subsequently, the case file was forwarded to the Office of Administrative Law Judges on or about November 24, 1999 (DX 179, 180).

Following numerous motions, procedural rulings, and continuances, as well as the further development of the medical evidence, I issued an Order Granting the Parties' Motion for Cancellation of the Hearing and for a Decision on the Record, dated November 26, 2001. However, the procedural motions and rulings persisted thereafter. Most of the foregoing involved Employer's multiple, somewhat redundant, arguments, challenging the validity of the regulations.

The documentary evidence which has been admitted in evidence consists of Director's Exhibits 1-182 (DX 1-182), Claimant's Exhibits 1-3 (CX 1-3), and Employer's Exhibits 1-6 (EX 1-6).[2] The findings of fact and conclusions of law which follow are based upon my analysis of all relevant documentary evidence admitted, the testimony presented (DX 44-B), and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Issues

The primary issues, as outlined in the Benefits Review Board's Decision and Order, dated September 30, 1998, are as follows:

I. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309.
II. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?

(DX 149).

[2]Claimant's Exhibits 1 through 3 were submitted under cover letters, dated August 18, 1999, March 1, 2000, and March 6, 2000, respectively. I note, however, that the cover letter, dated August 18, 1999, is obviously misdated, because the enclosed exhibit consists of Dr. Patel's rereading, dated February 22, 2000 of a July 13, 1999 film. Employer's Exhibits 1 through 6 were submitted under cover letters, dated April 4, 2000, October 10, 2000, December 22, 2000, December 27, 2000, January 8, 2001, and January 26, 2001. I also note that three documents which had previously been marked as Employer's Exhibits 1, 2, and 3, have been re-marked and are now identified in the record as Director's Exhibits 120, 124, and 123, respectively.

Findings of Fact and Conclusions of Law

Applicable Regulations and Case Law

The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. Among the provisions which does not apply retroactively is 20 C.F.R. § 725.309. *See* 20 C.F.R. § 725.2. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case. On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations. On appeal, the D.C. Circuit issued its decision in *National Mining Ass'n, et al v. Dep't of Labor*, ___F.3d___ (D.C. Cir. June 14, 2002), which further addressed the validity and application of the revised regulations. With the exception of a few provisions, the Court affirmed the validity of the revised regulations, as well as its retroactive application. Moreover, the Court held that the amended provision at 20 C.F.R. § 718.201(c), which states that pneumoconiosis is "recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure," is not impermissibly retroactive. In so ruling, the Court noted that the parties agreed that, in rare cases, pneumoconiosis is latent and progressive. As a result, the Court found that the amended regulation "simply prevents operators from claiming that pneumoconiosis is never latent and progressive."

As the Claimant last engaged in coal mine employment in West Virginia, this matter arises within the appellate jurisdiction of the Fourth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989)(*en banc*). Although it is well settled that "recency" by itself is an arbitrary benchmark for weighing evidence, and the "later is better" approach should not be mechanically applied, the Fourth Circuit has held that pneumoconiosis is a "progressive and irreversible" disease, such that it is proper to accord greater weight to later positive x-ray studies over earlier negative studies. The Fourth Circuit further stated generally, "later evidence is more likely to show the miner's current condition" where it is consistent in demonstrating a worsening of the miner's condition." *Lane Hollow Coal Co. v. Director, OWCP [Lockhart]*, 137 F.3d 799 (4th Cir. 1998).

The standard for determining whether a material change has occurred in the United States Court of Appeals for the Fourth Circuit was set forth in *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd*, 86 F.3d 1358 (4th Cir. 1996)(en banc), *cert. denied*, 117 S.Ct. 763 (1997), which followed the one-element standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994). Under this standard, I must first consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. At that point, I would be required to make a *de novo* review of the entire record, including that evidence which was submitted with the previous claim, in order to determine whether the Claimant is eligible for benefits.

Background and Employment History

The Claimant, Ray Duckworth, was born on February 12, 1922. He has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Lena (DX 2; DX 44B, pp. 11-12).

The parties stipulated, and I find, that the Claimant engaged in coal mine employment for at least 37 years ending on April 27, 1984; and, that the Employer, Eastern Associated Coal Corporation, is the properly designated responsible operator (DX 44-B, pp. 11-12).

At the formal hearing before me on September 26, 1986, Claimant testified that shortly before he retired, his miner was shut down because they were only running one miner. Accordingly, Claimant performed labor, such as tearing out track, "and one thing and another." When he tore the track up, it entailed manually lifting "sixty pound steel, thirty foot rails" with the help of six or seven other miners. Claimant stated that he couldn't perform such work, so he retired. However, Claimant testified that he only performed such work for about six months. Furthermore, he stated that during that period, "they'd load coal one day, and maybe do dead work three or four days." Moreover, Claimant testified that his last job classification was as a miner operator, and that the "dead work," was not part of his regular job operating the miner. When asked whether he would describe his work as a miner operator, and dead work, as light duty, Claimant responded: "No, I wouldn't. Miner operator, operating the miner was all right, but doing dead work, like when it come (sic) time to move the power center, you had to drag all your cable, some of the cable was about that big, your main power line." (DX 44-B, pp. 13-15).

The record also contains job descriptions as set forth in written statements by the Claimant and two co-workers, in February and March 1984 (*i.e.*, approximately two months before Claimant left coal mine employment) (DX 27-29). Co-worker, Clifton E. Tennant described the job duties as follows:

> The main function is to operate the continuous miner, whether it is to cut out coal or rock, but the job also requires that the operator also help whatever other work which may be required to complete the assigned work for each day.

(DX 29).

Co-worker, Archie Noshagga, described the job duties as follows:

> To run the miner and mine coal, set bits, clean water sprays and help pull cables and move power boxes, or whatever else needs done.

(DX 28).

Finally, the Claimant set forth the following written description of the duties in his job as a miner operator:

> Sitting entire shift; carry approx. 75 lbs. an average distance of 300 to 1000 feet; lift approx. 10 lbs. To 300 lbs.

(DX 27).

Interestingly, the Claimant's co-workers stated that he was unable to perform his duties satisfactorily for five or seven years. They stated that he needed assistance doing various duties, such as handling heavy cables, rock dusting, walking distances, and/or carrying bits (DX 28, 29). On the other hand, the Claimant stated that he was able to perform all of the duties satisfactorily, but noted that he periodically needed extra help or special consideration depending on what he was doing (DX 27).

Having carefully considered the relevant testimony and documentary evidence, I find that, even though Claimant's last coal mine employment entailed "dead work," such as tearing up track, that work was not performed regularly over a substantial period of time. Claimant's last *usual* coal mine job was as a miner operator. Taken as a whole, I find that the job primarily involved sitting at the controls operating the continuous miner. However, the job also entailed periodic moderately heavy exertion, such as pulling cables, lifting and carrying rock dust, bits, etc.

In his testimony on September 26, 1986, Claimant stated that he began smoking cigarettes when he was a young man, and that he still smoked approximately ½ pack per day (DX 44-B, p. 21). The more recent medical evidence indicates that the Claimant's smoking habit has continued thereafter. For example, on June 23, 1999, Dr. Rasmussen reported that Claimant smoked an average of "1/2 + pack of cigarettes a day" from age 16, in 1938, although Claimant "quit several times for 2 months at a time," Dr. Rasmussen noted he now smokes, but only irregularly (DX 176). In April 1976, however, Dr. Rasmussen reported that the Claimant had already smoked "three-fourths pack of cigarettes daily for 46 years." (DX 19). Moreover, on July 29, 1999, Dr. Renn reported that Claimant smoked ½ pack per day from 1930 to the present (DX 172). Accordingly, the record indicates that the Claimant has an extensive cigarette smoking history of approximately 70 years, and that he has continued to smoke cigarettes long after he left his coal mine employment.

"New" Medical Evidence

As stated above, the Claimant's prior claim was finally denied on July 25, 1980, when the Deputy Commissioner's office found that the Claimant did not establish any of the elements of entitlement (DX 34). Accordingly, the threshold issue is whether the Claimant has established a material change in conditions under § 725.309. Pursuant to the Benefits Review Board's Decision and Order, dated September 20, 1998 (DX 149), and the Fourth Circuit's holding in *Lisa Lee Mines v. Director, OWCP*, *supra,* I must initially consider all of the new evidence to determine if the Claimant has proven at least one of the elements of entitlement previously adjudicated against him.

The case file contains various chest x-ray interpretations, pulmonary function tests, arterial blood gas studies and medical opinions which were conducted and submitted after the July 25, 1980 final denial of the prior claim, as summarized below.

The record contains numerous x-ray interpretations of "recent" films, dated September 22, 1980 (DX 43), July 4, 1983 (DX 43), April 26, 1984 (DX 23, 24, 65, 66; EX 1, 4), June 4, 1984 (DX 43), November 21, 1986 (DX 46, 60, 61), September 21, 1988 (DX 62, 63, 59/176), November 28, 1988 (DX 63, 67, 68, 69), January 31, 1996 (DX 107, 108/109; EX 1, 4), July10, 1996 (DX 120, 125, 170), June 24, 1997 (EX 2), February 10, 1998 (EX 2), May 14, 1998 (EX 2), May 28, 1999 (EX 2), June 23, 1999 (DX 166/168/176, 167, 169; EX 3, 4), and July 13, 1999 (DX 172, 173; CX 1,3).

Of the 60 interpretations of the "recent" chest x-rays, only 9 are positive for pneumoconiosis under the classification requirements set forth in § 718.102(b), as follows: Dr. Hurst (1/0) and Dr. Cole (2/2) readings of the April 26, 1984 film; Dr. Speiden's (1/1) interpretation of the September 21, 1988 film; Dr. Patel (1/1) and Gaziano (1/1) readings of the January 31, 1996 film; Dr. Patel (1/2) and Dr. Gaziano (1/0) interpretations of the June 23, 1999 film; and, Dr. Patel (2/1) and Dr. Gaziano (1/2) readings of the July 13, 1999 film. All nine of the positive interpretations were made by B-readers. Furthermore, Drs. Hurst, Cole, Speiden, and Patel are dually-qualified B-readers and Board-certified radiologists.

On the other hand, the vast majority of the interpretations are negative for pneumoconiosis (no pleural or parenchymal abnormalities consistent with pneumoconiosis; 0/0 or 0/1) under the classification requirements set forth in § 718.102(b). Furthermore, almost all of the negative interpretations were also made by B-readers. Moreover, most were made by dually-qualified B-readers and Board-certified radiologists, such as Drs. Spitz, Wiot, Shipley, Wheeler, Scott, Gayler, Felson, Binns, Gogineni, Abramowitz, and Navani.

Finally, the three most recent, virtually contemporaneous, films, dated May 28, 1999, June 23, 1999, and July 13, 1999, respectively, were interpreted 16 times. Only four of the readings were positive for pneumoconiosis. Furthermore, the vast majority of the interpretations

by dually-qualified B-readers and Board-certified radiologists are negative for pneumoconiosis. Accordingly, I find that the x-ray evidence developed since the final denial of the prior claim fails to establish the presence of pneumoconiosis.

The record contains "recent" pulmonary function tests which were performed on April 26, 1984 (DX 20), September 21, 1988 (DX 59), November 28, 1988 (DX 64), January 31, 1996 (DX 103/176), July 10, 1996 (DX 120), June 23, 1999 (DX 165/176), and July 13, 1999 (DX 172). None of the tests are qualifying under the applicable regulatory criteria set forth in Part 718, Appendix B.

The case file also includes "recent" arterial blood gas studies which were administered on April 26, 1984 (DX 22), September 21, 1988 (DX 59/176), January 31, 1996 (DX 105/176), July 10, 1996 (DX 120), June 23, 1999 (DX 163/176), and July 13, 1999 (DX 172).

The reported results were as follows:

Date	Physician	PCO2	P02	
4/26/84	Reynolds	37.1	86.5	(Resting)
4/26/84	Reynolds	37.1	84.8	(Exercise)
9/21/88	Rasmussen	39	70	(Resting)
9/21/88	Rasmussen	37	74	(Exercise Test 1)
9/21/88	Rasmussen	37	65	(Exercise Test 2)
9/21/88	Rasmussen	36	63	(Exercise Test 3)
1/31/96	Rasmussen	39	78	(Resting)
1/31/96	Rasmussen	37	65	(Exercise Test 1)
1/31/96	Rasmussen	36	63	(Exercise Test 2)
7/10/96	Renn	43	74	(Resting)[3]
6/23/99	Rasmussen	39	71	(Resting)[4]
7/13/99	Renn	40	72	(Resting)[5]

[3]A note from Dr. Karl J. Myers, Jr., dated May 29, 1996, states that the Claimant should not undergo another stress test, because of his heart problems (DX 120). Furthermore, Dr. Renn reported, on July 17, 1996, that a cardiopulmonary stress evaluation was not offered due to Claimant's age. However, the resting blood gas test was described as "normal for his age." (DX 120).

[4]Dr. Rasmussen stated that "exercise studies were not performed...because Mr. Duckworth felt that he was too weak to be able to walk on the treadmill." However, Dr. Rasmussen interpreted the June 23, 1999 resting arterial blood gas test as "normal." (DX 163/176).

[5]In his report, dated July 20, 1999, Dr. Renn stated that a cardiopulmonary stress evaluation was not offered to Claimant, because the equipment was inoperative. However, Dr. Renn interpreted the resting blood gas test as "normal for his age." (DX 172).

As outlined above, none of the resting arterial blood gas studies are qualifying under the applicable regulatory criteria set forth in Part 718, Appendix C. In fact, the recent resting studies were normal. Furthermore, the April 26, 1984 exercise test is also clearly not qualifying. In addition, the earlier level(s) of exercise studies on September 21, 1988 and January 31, 1996 were also not qualifying.. On the other hand, the final exercise tests on September 21, 1988 and January 31, 1996 yielded qualifying results, albeit only minimally below the applicable standards. In view of the clearly nonqualifying, normal, recent blood gas studies, and the marginally qualifying recent exercise blood gas tests, I find that, taken as a whole, the recent arterial blood gas evidence neither precludes nor establishes a totally disabling respiratory or pulmonary impairment.

The case file also includes the "recent" medical opinions of Drs. Reynolds (DX 21), Lapp (DX 46), Gaziano (DX 50), Rasmussen (DX 59, 104, 125, 164, 176; CX 2), Renn (DX 64, 120, 123, 172; EX 5), Fino (DX 124), Sherman (DX 181), and Tuteur (EX 6).

Dr. Grace M. Reynolds examined the Claimant on April 26, 1984 (DX 21). Dr. Reynolds reported a coal mine employment history of 36 years, including 20 years working for the Employer running the miner; and, an ongoing cigarette smoking history of ½ pack for 40-45 years. In addition, Dr. Reynolds set forth Claimant's subjective complaints and physical findings on exertion. Furthermore, as outlined above, Dr. Reynolds obtained or administered various clinical tests, including a chest x-ray which initially was interpreted a positive for pneumoconiosis (DX 23,24), but which was subsequently reread as negative for pneumoconiosis (DX 65,66; EX 1); a nonqualifying pulmonary function test (DX 20), and nonqualifying resting and exercise blood gas studies (DX 22). In summary, Dr. Reynolds reported "CWP" and "COPD" as cardiopulmonary diagnoses. In addition, she marked the "Yes" box of the form report indicating that the diagnosed conditions are related to dust exposure in Claimant's coal mine employment. However, Dr. Reynolds failed to provide any rationale for this opinion and did not address the total disability issue. Interestingly, Dr. Reynolds interpreted the pulmonary function test as showing "moderate small airway obstructive disease," even though the FVC, FEV1, and MVV results were 104%, 96%, and 85% of predicted normal, and the preliminary report, as set forth on the computerized printout, stated that the test only "suggests mild obstructive airways." (DX 20).

Dr. N. LeRoy Lapp, a B-reader who is Board-certified in Internal Medicine and Pulmonary Diseases (DX 47), examined the Claimant on November 21, 1986. In his report, dated December 4, 1986 (DX 46), Dr. Lapp set forth the Claimant's occupational history. He noted that the Claimant worked as a miner operator for more than 20 years, but that during the last six months, Claimant worked as a general laborer, tearing out track, loading heavy steel, and carrying posts. Dr. Lapp's report also sets forth the Claimant's medications, symptoms, past medical history, family and social histories, and an ongoing smoking history of ½ pack per day which "started at age eight" (*i.e.,* 1930). In addition, Dr. Lapp reported physical findings on examination and clinical test results, including chest x-ray, pulmonary function study, resting arterial blood gases, and resting electrocardiogram. Based upon the foregoing, Dr. Lapp concluded:

> I do not find evidence of Coalworkers' Pneumoconiosis nor any obstructive or restrictive primary lung disease to account for his symptoms. He does have suggestive evidence of pulmonary vasospastic disease and also some possible cardiomyopathy. The latter needs to be evaluated by a Cardiologist and most likely needs a catheterization. In my opinion Mr. Duckworth does not have Coalworkers' Pneumoconiosis and he is not totally disabled due to Coalworkers' Pneumoconiosis. He does in fact have a cardiac disease and pulmonary vascular disease which needs to be further evaluated, of non-occupational origin.

(DX 46).

Dr. D. Gaziano provided a "Medical Consultant Case Review," dated May 26, 1988 (DX 50). A U.S. Department of Labor claims examiner set forth the following statement, as fact: "The miner has CWP with 30 years of proven coal mine employment. Therefore, presence and causality have been established." (DX 50). The claims examiner, then, instructed Dr. Gaziano to review the case file, in particular, Dr. Lapp's report, dated December 4, 1986, to determine if the Claimant suffers from cor pulmonale. The full text of Dr. Gaziano's handwritten response is as follows:

> The Claimant has cor pulmonale. I shall limit my response to the narrow issue as to the presence or absence of cor pulmonale. The neck vein distension clearly indicates there is right heart failure. The echocardiogram eliminates left ventricular failure as a cause of right ventricular failure. In the absence of mitral stenosis we are left as the lung as the cause of the right heart failure. This is by definition cor pulmonale.

(DX 50).

Dr. Donald D. Rasmussen is a B-reader who is Board-certified in Internal Medicine and Forensic Medicine and also has significant experience in pulmonary diseases (DX 125, pp. 3-6; Rasmussen Deposition Exhibit 1). Dr. Rasmussen issued multiple medial reports, dated September 21, 1988 (DX 59/176), January 31, 1996 (DX 104/176), June 23, 1999 (DX 164/176), September 22, 1999 (CX 2), and February 21, 2000 (CX 2).[6] Furthermore, Dr. Rasmussen testified at deposition on September 24, 1996 (DX 125).

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[6]Dr. Rasmussen had also issued another report (DX 19). Although the report is undated, the related clinical tests indicate that the report was issued on or about April 14, 1976 (DX 19). Since the report apparently was issued before the final denial of the prior claim, it is not directly relevant to the "material change in conditions" issue. I note, however, that; in 1976, Dr. Rasmussen estimated Claimant's overall loss of functional capacity as 30-40%, and concluded that Claimant appeared "capable of performing steady work at light work levels." (DX 19). In fact, Claimant continued to engage in coal mine employment for approximately 8 more years after Dr. Rasmussen made this assessment.

In his reports, dated September 21, 1988 (DX 59/176), January 31, 1996 (DX 104/176), and June 23, 1999 (DX 164/176), Dr. Rasmussen set forth the Claimant's occupational history, somewhat inconsistent smoking histories, past medical history, family history, subjective complaints, physical findings on examination, and the results of various clinical tests.

On September 21, 1988, Dr. Rasmussen concluded:

> These studies indicate moderately severe loss of respiratory functional capacity as reflected by his reduced diffusing capacity and the marked impairment in oxygen transfer during exercise.
>
> The patient's pulmonary impairment would clearly render him totally disabled for resuming his former coal mine employment with its attendant requirement for heavy manual labor.
>
> This patient has a long history of coal mine dust exposure. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he does have coal workers' pneumoconiosis which arose from his coal mine employment.
>
> The two primary risk factors in this patient's pulmonary insufficiency appear to be his cigarette smoking and his coal mine dust exposure with its resultant coal workers' pneumoconiosis. There is no clear way in which a separation can be made between these two factors, however, in the absence of overt obstructive insufficiency, one could attribute his impairment more to his coal mine dust exposure than to his cigarette smoking. It is, therefore, medically reasonable to conclude this patient has totally disabling respiratory insufficiency which is primarily the consequence of his coal mine dust exposure with its resultant pneumoconiosis.

(DX 59/176).

Following his evaluation of the Claimant on January 31, 1996, Dr. Rasmussen reached the same conclusion, using similar language, as follows:

> Overall, these studies indicate moderately severe loss of respiratory function as reflected principally by the reduced diffusing capacity and the distinct increase in dead space ventilation and impairment in oxygen transfer during light to moderate exercise. This degree of impairment would render this patient totally disabled for resuming his former coal mine employment with its attendant requirement for heavy and some very heavy manual labor.

> This patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he has coalworkers' pneumoconiosis which arose from his coal mine employment.
>
> The two risk factors in this patient's impaired respiratory function are his cigarette smoking and his coal mine dust exposure. The latter is most significant in view of the pattern of impairment in which there is much more gas exchange impairment than ventilatory impairment.

(DX 104/176).

Dr. Rasmussen also reached the same conclusion, and employed similar language, following his June 23, 1999 examination, as follows:

> Overall, these studies indicate at least moderately severe loss of respiratory function as reflected by the reduced single breath diffusing capacity and the DL/VA. It is also noteworthy that this patient exhibited similar decrease in single breath carbon monoxide diffusing capacity in a study performed January 31, 1996. In addition, during exercise, he showed significant impairment in oxygen transfer with PACO2 36, PAO2 63 during light to moderate exercise. The patient also had abnormal exercise blood gas studies in a prior study of 1988 with essentially the same blood gas finding at a slightly higher exercise level.
>
> Based on the patient's reduced diffusing capacity and his previous blood gas studies, he is totally disabled for resuming his last regular coal mine job with its requirement for heavy manual labor.
>
> This patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he has coalworkers' pneumoconiosis which arose from his coal mine employment.
>
> The two risk factors for this patient's disabling respiratory insufficiency are his cigarette smoking and his coal mine dust exposure. His coal mine dust exposure must be considered a major contributing factor to his disabling respiratory disease.

(DX 164/176).

Notwithstanding his apparent reliance, at least in part, upon positive x-ray interpretations to diagnose coal worker's pneumoconiosis, Dr. Rasmussen testified at deposition, on September 24, 1996, as follows: "We certainly see coal miners who have no X-ray evidence (of pneumoconiosis) yet they may have physiologic evidence and anatomic evidence of coalworkers' pneumoconiosis. If I did not make a diagnosis of coal pneumoconiosis (by X-ray) in this case, I

still would have felt that his coal mine dust exposure was a major factor in his lung disease simply because the X-ray is, (a) imperfect, and (b), may well be negative even with significant pneumoconiosis present." (DX 125, p. 13). Specifically, Dr. Rasmussen testified that, because of the pattern of impairment in this case, in which there was only a mild obstructive impairment shown on ventilatory function, but a marked impairment in exercise gases, he would "still be comfortable in concluding coal mine dust exposure is the more likely contributor to his impairment, even if the x-ray evidence would happen to be negative." (DX 125, p. 14). However, Dr. Rasmussen also testified that, assuming there was mild irreversible airway obstruction and no impairment whatsoever on exercise, he would still find that coal mine dust exposure was probably a major or significant contributing factor, because he would be unable to distinguish between the Claimant's cigarette smoking and coal mine dust exposure. Furthermore, Dr. Rasmussen reiterated that he would reach this conclusion even if the x-ray evidence were negative (DX 125, pp. 19-20).

Dr. Rasmussen also issued supplemental reports, dated September 22, 1999 and February 21, 2000, in response to correspondence from Claimant's counsel (CX 2).

On September 22, 1999, Dr. Rasmussen cited the June 23, 1999 examination, in particular the single breath carbon monoxide diffusing capacity, whose results "would be considered marked impairment, clearly sufficient to render the patient disabled from performing heavy manual labor." Furthermore, Dr. Rasmussen, again, stated that the 1988 and 1998 (sic) exercise blood gas studies were "clearly abnormal" and "clearly out of proportion to his ventilatory impairment." In conclusion, Dr. Rasmussen stated: "The pattern of impairment is one clearly associated with coalworkers' pneumoconiosis." Finally, Dr. Rasmussen noted that he was "not in receipt of studies performed by others." (CX 2).

On February 21, 2000, Dr. Rasmussen reiterated that, even though the pulmonary function study and resting blood gas study results do not "meet the listings," Claimant "was nonetheless disabled as a consequence of his reduced single breath carbon monoxide diffusing capacity under the criteria of the American Thoracic Society and the American Medical Association. Specifically, Dr. Rasmussen described the results of the foregoing test as 42% of predicted, which would be considered a moderate impairment by the American Thoracic Society (CX 2).

Dr. Joseph J. Renn, III, is a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease. Dr. Renn issued multiple reports, dated December 6, 1988 (DX 64), July 17, 1996 (DX 120), and July 20, 1999 (DX 172). Furthermore, Dr. Renn testified at depositions held on September 13, 1996 (DX 123) and December 14, 2000 (EX 5).

In his reports, Dr. Renn set forth the Claimant's occupational history, cardiopulmonary history, smoking history, personal, family, and past medical history, family history, physical findings on examination, and the results of various clinical tests. Furthermore, in his more recent reports, Dr. Renn also considered the other available medical data, as obtained and/or administered by other physicians.

On December 6, 1988, Dr. Renn concluded:

> IMPRESSION: Mr. Ray Duckworth has Raynaud's disease, iatrogenic hypothyroidism and possibly some type of cardiac arrhythmia. He does not have pneumoconiosis. He does not have any significant ventilatory impairment. When considering only his respiratory system, it is with a reasonable degree of medical certainty that he is not totally and permanently impaired to the extent he would be unable to perform his last known coal mining job of continuous miner operator or any similar work effort. It is with a reasonable degree of medical certainty Mr. Ray Duckworth's Raynaud's disease, iatrogenic hypothyroidism and possible cardiac arrhythmia were neither caused, nor contributed to, by his exposure to coal mine dust.

(DX 64).

Following his evaluation of the Claimant in July 1996, Dr. Renn concluded:

> IMPRESSION: Mr. Ray Duckworth has chronic obstructive pulmonary disease, likely early emphysema, carboxyhemoglobinemia, supraventricular cardiac arrhythmia and, by past medical history, Raynaud's disease and iatrogenic hypothyroidism. He does not have pneumoconiosis. He has a mild, significantly bronchoreversible obstructive ventilatory defect. When considering only his respiratory system, it is with a reasonable degree of medical certainty that he is not totally and permanently impaired to the extent he would be unable to perform his last known coal mining job of continuous miner operator or any similar work effort. When considering the whole man, he is so impaired. It is with a reasonable degree of medical certainty Mr. Ray Duckworth's chronic obstructive pulmonary disease, carboxyhemoglobinemia, supraventricular cardiac arrhythmia, Raynaud's disease and iatrogenic hypothyroidism were neither caused, nor contributed to, by his exposure to coal mine dust. It is with a reasonable degree of medical certainty Mr. Ray Duckworth's chronic obstructive pulmonary disease resulted from his years of tobacco smoking rather than exposure to coal mine dust.

(DX 120).

In July 1999, Dr. Renn provided a similar opinion, despite misstating Claimant's last usual coal mine job as a cutting machine operator instead of a continuous miner operator, as follows:

> Mr. Ray Duckworth has chronic obstructive pulmonary disease which is likely early emphysema and, by past medical history, Raynaud's disease and iatrogenic hypothyroidism. He does not have pneumoconiosis. He has a mild obstructive ventilatory defect of insufficient degree to prevent him from being able to perform either his last known coal mining job of cutting machine operator or any similar work effort. It is with a reasonable degree of medical certainty Mr. Ray

> Duckworth's chronic obstructive pulmonary disease which is likely early emphysema, Raynaud's disease and iatrogenic hypothyroidism were neither caused, nor contributed to, by his exposure to coal mine dust. It is with a reasonable degree of medical certainty Mr. Ray Duckworth's chronic obstructive pulmonary disease resulted from his years of tobacco smoking rather than exposure to coal mine dust.

(DX 172).

Dr. Renn also testified at depositions held on September 13, 1996 (DX 123) and December 14, 2000 (EX 5). In both depositions, Dr. Renn addressed the bases for his conclusions regarding the pneumoconiosis, total disability, and causation issues, while specifically addressing Dr. Rasmussen's contrary opinion.

In 1996, Dr. Renn specified that his use of the term pneumoconiosis, included the regulatory definition, namely, a respiratory condition caused or contributed by occupational exposure (DX 123, p. 19). Furthermore, Dr. Renn clearly stated that his finding of no pneumoconiosis was not based solely on the X-ray evidence. To the contrary, Dr. Rasmussen also noted bronchoreversibility on some of the pulmonary function tests, which is inconsistent with pneumoconiosis (DX 123, p. 21). Moreover, Dr. Renn stated that Dr. Rasmussen's reliance on the reduced diffusing capacity to diagnose coal worker's pneumoconiosis was misplaced, because the extent of reduction indicated that it was related to cigarette smoking rather than coal dust exposure (DX 123, p. 27). In summary, Dr. Renn found no pneumoconiosis after considering the evidence "historically, physically, clinically, and physiologically, and radiographically." Based upon the foregoing, Dr. Renn opined that the Claimant's chronic obstructive pulmonary disease is caused by tobacco smoking (DX 123, p. 42). In addition, Dr. Renn stated that the Claimant does not suffer from cor pulmonale or congestive heart failure. In making this determination, Dr. Renn stated, in pertinent part, that cor pulmonale does not disappear without treatment. Here, the Claimant was not receiving any treatment for the condition. In fact, Dr. Renn testified that Claimant's medication (*i.e.,* Inderal), a beta blocker agent, can actually aggravate cor pulmonale, heart failure, and obstructive airways disease. Furthermore, Dr. Renn testified that the Claimant has never had a manifestation of cor pulmonale. Unlike left ventricular failure, which could be intermittent and cause paroxysmal dyspnea, Dr. Renn stated that if cor pulmonale is present, it remains present without treatment. While Dr. Renn acknowledged that neck vein distention suggests right-sided heart failure, Dr. Renn testified that he did not find neck distention either time he examined the Claimant. Moreover, Dr. Renn did not find any evidence of cor pulmonale or any type of congestive heart failure. In addition, Dr. Renn acknowledged that, in assessing whether or not right-sided failure is being caused by left-sided failure, an echocardiogram may be of assistance but, he stated that it should not be the only criteria. Furthermore, Dr. Renn stated that it depends upon the technical quality of the echocardiogram, and, also noted that it is sometimes very difficult to assess the wall thickness. Finally, Dr. Renn explained that cor pulmonale entails right heart failure caused by a pulmonary disease. Thus, even if an echocardiogram might suggest right-sided enlargement, it is not the same as a diagnosis of cor pulmonale. (DX 123, pp. 38-40).

In his deposition testimony on December 14, 2000, Dr. Renn further expounded on the bases for his opinion (EX 5). While acknowledging that coal mine dust exposure can cause an obstructive occasion in some cases (EX 5, p. 12), Dr. Renn explained, in detail, why Claimant's obstructive lung disease is not related to coal mine dust exposure:

> I've come to that conclusion because of the physiologic pattern, or should I say the pathophysiologic pattern of the ventilatory studies. In coal workers' pneumoconiosis it is known that there is a proportionate reduction of volumes and flows such as to result in normalization of the FEV1 and the FVC ratio. It's known that there is, in tobacco smoking, that there is a disproportionate reduction of the volumes and flows in the spirometric studies.
>
> In Mr. Duckworth on his studies of November 28, 1988 he had what could be interpreted as an early reduction of the mid-flow or the FEF25-75%, which as first put forth I believe by Doctor Thomas Petty, was the earliest manifestation of a effect of tobacco smoking. However, in Knudson predicted equations for 1983 the FEF25-75% in a person who was 66 years old at the time can be as low as in the low 40% range and still be normal. So technically speaking it could be said that even the FEF25-75% was not affected by the standards used for the Knudson predicted equations of 1983 when Mr. Duckworth was evaluated in 1988.
>
> In 1999, however, we have a different picture entirely. We have a marked change in the volume and flows. There is a disproportionate reduction of the volumes and flows. There's preservation of the, or normalization if you will, of the forced vital capacity. There's a disproportionate reduction of the FEV1 compared to the forced vita capacity. And there is a reduction of the FEF25-75%, which is the most severe reduction of all.
>
> This is the pattern that is appreciated with tobacco smoking. It's not the pattern you would see with simple coal workers' pneumoconiosis.
>
> Additionally, in simple coal workers' pneumoconiosis what you will see is a relative reduction of the total lung capacity, but not below 90% of predicted. You'll see a relative elevation of the residual volume, but not greater than 120% of predicted. And we do not see that in Mr. Duckworth. What we do see is a normal total lung capacity and a relatively normal residual volume indicating that the level of his obstructive airways disease which would be characterized according to the American Thoracic Society's statement on interpretation as a minima obstructive ventilatory defect.
>
> What we see is that he does not have air trapping, and he does not have hyperinflation based upon the lung volume studies.

> The diffusing capacity study is another question. It's quite reduced. In fact, it is moderately reduced. It was corrected for hemoglobin and carboxyhemoglobin and it remained 51% of the predicted value. The diffusing capacity between 1988 and 1999 showed a significant decrement. It was normal in 1988 but it showed a decrement in 1999 to be moderately reduced.
>
> The diffusing capacity in simple coal workers' pneumoconiosis has been found to be reduced. However, it is reduced approximately 12% to 13% below normal, but not below 80% of predicted. The diffusing capacity also has been found to be most often in individuals who have simple coal workers' pneumoconiosis of the P opacity variety. And again, we have the preponderance of the radiographic evidence in this case showing that he does not have simple coal workers' pneumoconiosis of any particular opacity.
>
> In tobacco smoking individuals we know that the diffusing capacity will be reduced. It will be reduced quite low depending upon the amount of emphysema that is preset as a result of tobacco smoking. There are other factors that effect the diffusing capacity, such as the carboxyhemoglobin, the level of hemoglobin, the fact that an individual has recently smoked tobacco, maybe recently has drunk alcohol, et cetera. Bu trying to account for those factors as much as possible we find that the diffusing capacity is moderately reduced in Mr. Duckworth, whereas it was normal in 1988, it's markedly below what you would associate with simple coal workers' pneumoconiosis especially early simple coal workers' pneumoconiosis, and it does not have the pattern of an interstitial lung disease. It has the pattern of an emphysematous or emphysema type reduction of the diffusing capacity.
>
> The reason I say that is because the diffusing capacity, the raw number is reduced itself. But when you consider the alveolar volume which was done in Mr. Duckworth, then the alveolar volume shows that there is a partial correction, at least, toward normal. That you would not expect with simple coal workers' pneumoconiosis. You would expect in an interstitial disease process for it to remain approximately the same. But it does correct toward normal when the alveolar volume is considered and that's consistent with a tobacco smoking induced chronic pulmonary disease rather than simple coal workers' pneumoconiosis.

(EX 5, pp. 12-17).

In addition, Dr. Renn reiterated his opinion that the Claimant does not suffer from a totally disabling respiratory impairment, even when one considers the heavy manual labor which Claimant performed in his *non*-usual coal mine job, such as lifting and carrying rails (EX 5, pp. 18-20). In reaching this conclusion, Dr. Renn testified, in pertinent part:

> I believe he is not totally and permanently disabled as a result of his mild obstructive ventilatory impairment. I based that upon my interviews with Mr. Duckworth wherein I reviewed with him on two occasions the part of his job that he did which were, to phrase the question, I asked him the hardest and heaviest parts of his last job. And he told me on both occasions that the mine was working out, in other words it was being closed and they were bringing equipment out and he was involved with tearing out track, setting posts, loading rails on the rail truck, in addition to his regular job as a continuous miner operator. And he told me the hardest part of the job was the manual labor, and indeed, I agree with him that that was hardest part of his job was performing those. Because having interviewed many coal miners over the years I'm very familiar with their jobs, in addition to having gone into the mines on three occasions myself and spent eight-hour working days observing the various jobs that were being performed.
>
> He said the heaviest part of the job was lifting 80 pound rails with the assistant (sic) of six or seven other men. Now what that means is that those rails he believed were not just the total rail weighing 80 pounds, but the rail was 80 pound per foot. And I have no reason to quarrel with that. That's why it requires six or seven other men to help lift the rail. That would be classified as heavy manual labor.
>
> According to his ventilatory function studies his FEV1 in 1999 was 79% of predicted both before and after bronchodilator. That is adequate ventilatory function to perform heavy manual labor for extended periods of time.
>
> However, we have to consider also the diffusing capacity study. The diffusing capacity is right at the level that an exercise study either may or may not demonstrate that he would have mild exercise induced relative hypoxemia. However, at this level, with the diffusing capacity corrected for alveolar volume above 55% of predicted, one would suspect that an exercise blood gas study would reveal, at the worst, perhaps a slight decrease in the oxygen tension during exercise, and even that may not occur. It would require several minutes of exercise in order for the decrease in oxygen tension to occur. And over those several minutes of exercise I'm sure that picking up and moving a rail, it would be carried any great distance. And so the other jobs that he told me about doing wold not be of adequate duration of time to result in exercise induced hypoxemia of such degree that he would not be able to recover from the oxygen debt that he incurred.

(EX 5, pp. 18-20). Finally, Dr. Renn reiterated that, in his opinion, Claimant's impairment is not related to coal dust exposure (EX 5, p. 20).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 6), issued a lengthy report, dated September 19, 1996, in which he

reviewed the available medical evidence (DX 124). At the end of his 15+ page report, Dr. Fino stated:

Conclusions

1. There is insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis.

2. It is my opinion that this man does not suffer from an occupationally acquired pulmonary condition.

3. There is a mild obstructive ventilatory impairment with a mild oxygen transfer impairment secondary to smoking.

4. If this man had to perform continuous heavy manual labor all day he would be disabled.

5. For his job as described to the physicians of record he is not disabled.

6. Even if he had coal workers' pneumoconiosis, this wold not change my opinion regarding the degree and cause of disability.

7. Finally, I would note that this man's impairment is related to cigarette smoking. The impairment would not be present had he never smoked.

(DX 124).

Dr. Michael S. Sherman, who is Board-certified in Internal Medicine, Pulmonary Disease, and Critical Medicine (DX 182), issued a report, dated October 22, 2000, in which he answered various questions, which apparently had been posed by the District Director's office (DX 181). In summary, Dr. Sherman stated that "there are a number of reports indicating that significant disease can occur after a miner retires, and that disease can progress even after a miner is no longer exposed to coal dust." (DX 182, pp. 1-3). Secondly, Dr. Sherman cited medical literature to support the general proposition that, if a miner has an obstructive impairment, it can be due to coal mine dust exposure (DX 182, pp. 3-7). Thirdly, Dr. Sherman summarized most of the chest x-ray, pulmonary function, and arterial blood gas results, and provided a cursory summary of two of Dr. Rasmussen's reports, a one-sentence summary of an unidentified report by Dr. Renn, and Dr. Lapp's report, dated October 13, 1986 (DX 182, pp. 7-8). Fourthly, Dr. Sherman described Claimant's last coal mine job as "a coal miner which included pulling and hanging heavy electrical cable, setting timbers, tearing out track, and other very heavy manual labor." In addition, Dr. Sherman cited a 1984 form in which Claimant stated he felt he has lung disease based on symptoms of shortness of breath, wheezing, productive cough, and dyspnea on exertion. Furthermore, Dr. Sherman mention the 1984 form prepared by Claimant's co-worker, Clifton Tennant, indicating that Claimant could not carry out duties satisfactorily due to shortness of breath (DX 182, pp. 8-9).

Finally, Dr. Sherman addressed questions regarding the presence of pneumoconiosis; its causal relationship to coal mine employment; total disability; and the onset of such disability, respectively. The full text of his responses to these issues is as follows:

> Mr. Duckworth has obstructive lung disease as evidenced by his recent pulmonary function tests, which show mild obstructive disease on spirometry and a moderate to severe reduction in the diffusing capacity (DLCO). Evidence outlined above demonstrated that obstructive lung disease can occur from coal dust exposure, thus meeting the criteria for the legal definition of coal workers' pneumoconiosis. Mr. Duckworth also has a significant smoking history. It is likely that both exposures contributed to his obstructive lung disease.
>
> Mr. Duckworth has no other occupational exposure listed in the evidence that would cause pneumoconiosis other than coal mining.
>
> Mr. Duckworth's last two jobs in the coal mine industry were as a continuous miner operator and a general laborer. The job descriptions supplied to me indicate that heavy manual labor was required for both these jobs. The dyspnea on exertion, reduction in diffusion capacity, and pulmonary response to exercise indicate that his respiratory function is not sufficient to perform these jobs. As noted above, the cause of the disabling respiratory impairment is likely to be a combination of smoking and coal dust inhalation. Although his measured pulmonary function was not significantly impaired in 1988, studies by Dimich-Ward et al show that continued decline in pulmonary function may occur to a miner even after requirement.
>
> I cannot establish this (onset of total disability due to pneumoconiosis) conclusively based on the data supplied to me. Pulmonary function tests, including diffusion capacity and resting/exercise blood gas analysis, indicate normal function as late as 1988. However, Mr. Duckworth clearly had symptoms of exertional dyspnea prior to that which was limiting his capacity to work (based on his 1984 self report as well as his coworkers' [sic] report). Additionally, there is no convincing evidence for a cardiac cause of dyspnea in 1984. However, the earliest confirmatory laboratory evidence for a pulmonary impairment was not until January of 1996.

(DX 181, p. 9).

Dr. Peter G. Tuteur , a Board-certified pulmonary specialist with extensive experience (EX 6, pp. 5-8), testified most recently at deposition on January 16, 2001. Following his analysis of the available medical data (EX 6, pp. 8-9), Dr. Tuteur opined that "Mr. Duckworth does not have a coal mine dust induced lung disease that is clinically significant, physiologically significant, or radiographically significant" based upon the "totality of the available medical data." (EX 6, p. 9).

More specifically, Dr. Tuteur provided the following analysis regarding the data which he relied upon in making a determination regarding the Claimant's clinical picture: Historical data, including childhood pertussis or some similar acute severe childhood disease involving the lungs; and persistent cough, often productive, since that early childhood illness. Such an early childhood pulmonary illness, puts him at higher risk for obstructive lung disease as an adult. A one year exposure as a molder at a foundry, at age 18, put him at some risk of developing silicosis. Claimant's 35-year underground coal mine employment history ending in 1984 clearly constituted sufficient coal dust exposure to produce coal worker's pneumoconiosis in a susceptible host. Claimant's cigarette smoking history, which began at about age eight and continued throughout his adult life, with rates up to two packs a day, put him at increased risk of various tobacco-related health problems, including chronic obstructive pulmonary disease, arteriosclerotic heart disease, and lung cancer. Claimant's clinical course and symptomatology. Physical findings on pulmonary examination which "waxed and waned." Clinical test results, such as some pulmonary function studies where the reduction in FEV1 correlates to a cigarette smoker. The fluctuation in results on arterial blood gas studies. Based upon the foregoing, Dr. Tuteur opined that the pattern of impairment here is typical of a cigarette smoke induced impairment, as well as for someone who had a childhood pertussis (EX 6, pp. 9-22). In addition, Dr. Tuteur cited the radiographic evidence and found no evidence of clinical silicosis (EX 6, pp. 22-23). While acknowledging, on cross-examination, that when coal dust and cigarette smoking are both present the risk of COPD *could* be greater than when either of these exposures are present alone (EX 6, p. 38), Dr. Tuteur specified that when he was discussing the absence of pneumoconiosis, he was not simply talking about "classical coal workers' pneumoconiosis," but also "airways disease that may be associated with and caused by the chronic inhalation of coal mine dust." Furthermore, Dr. Tuteur noted that for the reasons outlined above, he also found that Claimant's "chronic bronchitis is caused by the chronic inhalation of tobacco smoke from age eight to at least age 77." (EX 6, pp. 24-25).

Pneumoconiosis

As summarized above, the clear preponderance of the recent x-ray evidence is negative for pneumoconiosis. Although the record does contain nine positive interpretations by B-readers and/or Board-certified radiologists, the vast majority of the interpretations, including those by similarly well-qualified physicians, are negative for pneumoconiosis under the classification requirements set forth in § 718.102(b). Accordingly, I find that the Claimant has failed to meet his burden of establishing pneumoconiosis under § 718.202(a)(1).

Section 718.202(a)(2) is inapplicable herein because there are no biopsy or autopsy findings of pneumoconiosis. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of § 718.304 does not apply because there is no evidence of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under § 718.202(a)(3).

Accordingly, the only possible remaining basis upon which pneumoconiosis may be established is under the provisions of § 718.202(a)(4). This subsection allows the Claimant to establish the existence of pneumoconiosis, as defined in § 718.201, based upon a well-reasoned medical opinion, even if the radiological evidence is negative for pneumoconiosis. This includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. § 718.201.

As outlined above, the record includes the "recent" medical opinions of Drs. Reynolds (DX 21), Lapp (DX 46), Gaziano (DX 50), Rasmussen (DX 59, 104, 125, 164, 176; CX 2), Renn (DX 64, 120, 123, 172; EX 5), Fino (DX 124), Sherman (DX 181), and Tuteur (EX 6).

In summary, Dr. Reynolds' 1984 report includes the diagnosis of CWP and COPD, and a check mark indicating that the conditions are related to coal mine employment. In 1986, Dr. Lapp reported that the Claimant did not show evidence of coal worker's pneumoconiosis, and that his health problems were non-occupational in origin. In 1988, Dr. Gaziano was instructed, as fact, that Claimant has pneumoconiosis. In his rather cursory memo, Dr. Gaziano opined that Claimant has cor pulmonale. Dr. Rasmussen issued multiple reports, in 1988, 1996, 1999, and 2000, and testified at deposition in 1996. On several occasions, Dr. Rasmussen cited Claimant's history and x-ray findings of pneumoconiosis as bases for diagnosing coal worker's pneumoconiosis. However, Dr. Rasmussen also stated, even assuming negative x-rays, the pattern of impairment is consistent with pneumoconiosis. Thus, he would find that the Claimant's respiratory impairment is primarily due to coal mine employment. Furthermore, Dr. Rasmussen opined that the clinical test results established that the Claimant could not perform his last usual coal mine job with its attendant heavy manual labor. Dr. Renn issued multiple reports in 1988, 1996, and 1999, and testified at depositions in 1996 and 2000. Dr. Renn did not diagnose clinical or legal pneumoconiosis. He attributed the Claimant's chronic obstructive pulmonary disease and chronic bronchitis to Claimant's incredibly long cigarette smoking history, not coal mine dust exposure. Dr. Renn provided a very thorough analysis, and concluded that he found no pneumoconiosis based on history, physical findings, clinically, physiologically, and radiographically. In particular, Dr. Renn found that the physiologic pattern is consistent with tobacco smoking, not coal worker's pneumoconiosis. In addition, Dr. Renn cited multiple reasons for finding that the Claimant does not suffer from cor pulmonale. Finally, Dr. Renn analyzed the evidence, in conjunction with the exertion level of Claimant's last usual coal mine job, as well as some of the more strenuous aspects of Claimant's last (not usual) job as a general laborer. Based upon his thorough analysis, Dr. Renn opined that Claimant is not totally disabled from performing such work. Dr. Fino provided a detailed summary of the available medical data, and opined that there is insufficient objective evidence to establish pneumoconiosis; that Claimant's respiratory or pulmonary impairment is secondary to smoking; and, although Clamant could not perform continuous heavy manual labor, he is able to perform the job as Claimant described to other physicians. Dr. Sherman opined that Claimant has totally disabling pneumoconiosis arising from coal mine employment. However, Dr. Sherman relied principally on medical literature which simply supports the proposition that an obstructive lung disease *can* occur from coal dust exposure. He also cited a grossly understated cigarette smoking history. Furthermore, Dr. Sherman's analysis is based primarily upon only a few, mostly old, medical opinions. In addition, Dr. Sherman focused on the more strenuous physical duties, which

characterized the Claimant's work as a general laborer, rather than the duties attendant in Claimant's last usual coal mine job as a miner operator. Finally, Dr. Tuteur provided a thorough analysis of the evidence, and found that the Claimant does not suffer from a significant coal mine dust induced lung disease clinically, physiologically, or radiographically.

Having carefully evaluated the conflicting medical opinions, I accord the most weight to Dr. Renn's opinion, as buttressed by those of Drs. Lapp, Fino, and Tuteur. I find that the foregoing opinions, in particular Dr. Renn's, is better reasoned and documented than the opinions of Drs. Reynolds, Gaziano, Sherman, and even Dr. Rasmussen's, despite the latter's multiple reports and deposition testimony.

Notwithstanding Claimant's extensive coal mine employment history ending in 1984, and medical literature which not only indicates that a pulmonary impairment can be coal mine dust-related, but that it can develop after a miner leaves coal mine employment, I find that the Claimant has failed to establish clinical and/or legal pneumoconiosis on the basis of the medical opinion evidence.

In making this determination, I note that Drs. Renn, Lapp, Fino, and Tuteur, are well-credentialed Board-certified pulmonary specialists. More importantly, I find that Dr. Renn's analysis, in particular, is the most comprehensive, because it provides the most thorough discussion of the pattern of impairment, in conjunction with the Claimant's history, physical findings, and clinical test results. Furthermore, I accord little weight to Dr. Gaziano's opinion, because he provided a very cursory analysis, and was told to assume that Claimant has pneumoconiosis. Dr. Sherman's report is far more lengthy, but he also discussed limited medical opinion evidence and grossly understated Claimant's cigarette smoking history. In addition, Dr. Reynolds failed to specify the basis for his diagnoses and/or why he found such conditions are related to coal mine employment. Furthermore, Dr. Rasmussen seemed to rely, at least in part, upon positive chest x-ray evidence. Subsequently, Dr. Rasmussen provided a far less persuasive analysis regarding why he felt the "pattern of impairment" was indicative of a coal mine-related disease, as compared with Dr. Renn's analysis of the pattern of impairment which indicated that it was smoking-induced. In addition, the well-documented opinions of Drs. Fino and Dr. Tuteur buttress Dr. Renn's opinion regarding the pneumoconiosis issue. Accordingly, the Claimant has failed to establish the presence of pneumoconiosis based upon the recent medical opinion evidence. Therefore, the Claimant has not established the presence of pneumoconiosis under § 718.202(a)(4), or by any other means.

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal worker's pneumoconiosis. In so holding, the Court cited the Third Circuit's holding in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997), which requires the same analysis.

Since the preponderance of the x-ray evidence is negative for pneumoconiosis, and the better reasoned medical opinion evidence also fails to establish clinical and/or legal pneumoconiosis, I find that pneumoconiosis has not been established under § 718.202(a). In view of the foregoing, Claimant has failed to establish a material change of conditions on the basis of the pneumoconiosis element of entitlement. Furthermore, in the absence of a finding of pneumoconiosis, Claimant also cannot establish a causal relationship between the disease and his coal mine employment.

Total Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* amended 20 C.F.R. § 718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may still be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* amended 20 C.F.R. § 718.204(b)(2)(i)-(iv).

As outlined above, the recent pulmonary function studies are not qualifying under the regulatory standards set forth in Part 718, Appendix B. In fact, the foregoing studies have generally been interpreted as reflecting only a mild impairment. Accordingly, Claimant has not established total disability under § 718.204(b)(2)(i).

The recent arterial blood gas studies yielded mixed results. The resting blood gases yielded nonqualifying, normal results. Furthermore, the 1984 early exercise test, and the earlier level exercise tests in 1988 and 1996 are also nonqualifying. On the other hand, the final exercise tests in 1988 and 1996 yielded barely qualifying results under the criteria stated in Part 718, Appendix C. Taken as a whole, I find that the arterial blood gas evidence is inconclusive. Accordingly, Claimant has failed to meet his burden of establishing total disability under § 718.204(b)(2)(ii).

Notwithstanding Dr. Gaziano's cursory analysis and finding of cor pulmonale, I find that the better reasoned and more credible medical evidence, in particular Dr. Renn's deposition testimony, establishes that the Claimant does not suffer from cor pulmonale with right-sided congestive heart failure. Therefore, the Claimant has also not established total disability pursuant to § 718.204(b)(2)(iii).

Finally, I find that the Claimant has also not established total disability on the basis of the recent medical opinion evidence. In making this determination, I have carefully reviewed the record, as instructed by the Board, in its Decision and Order, dated September 30, 1998 (DX 149), in order to ascertain the exertional requirements of Claimant's last usual coal mine job and compared them to the physicians' assessments of Claimant's ability to perform such work.

As set forth above, Claimant's last job, as a general laborer, during the approximately six months when the mine was closing down, did not constitute his last *usual* coal mine job. Thus, Clamant's "dead work," such as tearing up track, which entailed heavy exertion, was not his usual coal mine employment. To the contrary, Claimant's last usual coal mine job was as a miner operator, which primarily entailed sitting at the controls operating the continuous miner. It also involved some manual labor, however, such as pulling cables, lifting and carrying rock dust, bits, etc. Therefore, I find that Claimant's usual coal mine job, as a miner operator, required periodic moderately heavy work.

Having carefully reviewed the recent medical opinion evidence, I find that Dr. Renn's analysis is the most thorough regarding this issue as well. Furthermore, since I find that Claimant's last usual coal mine job entailed periodic moderately heavy work, I find that the opinion of Dr. Renn, as buttressed by Dr. Fino's opinion, is most persuasive and consistent with the credible clinical test results, including the clearly nonqualifying pulmonary function studies, the recent normal resting blood gases, the nonqualifying early stage exercise tests, and the marginally qualifying final stage exercise values. As suggested in the opinions of Drs. Renn and Fino, Claimant's respiratory or pulmonary impairment may preclude him from performing heavy manual labor on a continuous basis; however, it would not prevent him from performing the duties of his last usual coal mine job, as a miner operator. Accordingly, I find that total disability has also not been established on the basis of the reasoned medical opinion evidence, pursuant to § 718.204(b)(2)(iv).

Finally, I have weighed all of the recent evidence, both like and unlike. Notwithstanding a minority of positive chest x-rays, some qualifying exercise blood gas tests, and some medical opinions, such as those of Drs. Rasmussen, Gaziano, and Sherman, which would support a total disability determination, I find that the opinions of Drs. Renn and Fino, in conjunction with the majority of the negative chest x-ray interpretations, the non-qualifying pulmonary function studies, normal resting blood gases, earlier nonqualifying exercise blood gases, and the exertional requirements of Claimant's last usual coal mine job, do not warrant a finding of total disability under § 718.204(b). Accordingly, Claimant has also failed to establish a material change of conditions on the basis of the "total disability" element of entitlement.

Since the Claimant has failed to establish the presence of a totally disabling respiratory or pulmonary impairment, he clearly cannot establish total disability due to pneumoconiosis under § 718.204(c)(1). Furthermore, even assuming that Claimant's impairment were totally disabling, the better reasoned medical opinion evidence establishes that such impairment did not arise out of coal mine employment, but rather his approximately 70 years of cigarette smoking.

Conclusion

The medical evidence submitted in conjunction with the current claim fails to establish any of the elements of entitlement previously adjudicated against the Claimant. Therefore, I find that no material change in conditions has been established, and that the current claim must be denied on the same bases as the denial of the previous claim. *See* 20 C.F.R. § 725.309. Accordingly, I find that the Claimant is not entitled to benefits under the Act.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of Ray Duckworth for black lung benefits under the Act is hereby DENIED.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.